

South Carolina Department of Health and Human Services
Verification of Medicaid

To: _____

Re: _____

Medicaid Number: _____

Date: _____

☐ Medicaid coverage was entered into the Department of Health and Human Services computer system for the above-named individual

Application Date: _____

Medicaid Effective Date: _____

Medicaid End Date: _____

Computer Entry Date: _____

☐ The individual was determined eligible for limited benefits only.

Please be reminded that all bills must be submitted within six (6) months of the Computer Entry Date **AND** within three years of the date of service.

If you have any questions or concerns, please contact the Member Services Call Center at 888-549-0820.

DHHS User ID

Instructions Regarding Use of the DHHS Form 945, Verification of Medicaid

The DHHS Form 945, Verification of Medicaid is designed for use in the following situations:

1. When Medicaid is approved for the retroactive period (up to three months prior to the date of application) but was not entered in the Medicaid Eligibility Determination System (MEDS) at the same time the decision was made. In this situation, MEDS does not automatically generate a notice to the beneficiary.
2. When a beneficiary/authorized representative or provider requests verification of Medicaid coverage.